REFFERAL FOR HEALTH CARE/ SUPPORTIVE SERVICES STANDARD

Effective Date: 11-07-2020

I. PURPOSE

The purpose is to define and provide guidance as to what is allowable for the Referral for Health Care/Supportive Services service category, in accordance with HRSA standards.

II. DEFINITION

Referral for Health Care and Support Services directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. This service may include referrals to assist eligible clients to obtain access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).

III. PROGRAM GUIDANCE

Referrals for Health Care and Support Services provided by outpatient/ambulatory health care providers should be reported under the Outpatient/Ambulatory Health Services category. The primary goal of this service is to ensure clients are receiving all of the benefits/resources for which they are eligible.

Referrals for health care and support services provided by case managers (medical and non-medical) should be reported in the appropriate case management service category (i.e., Medical Case Management or Non-Medical Case Management).

Referrals may be made informally through community health workers or support staff as a part of an outreach program.

*Referrals Services are not provided as part of Outpatient/Ambulatory Medical Care or Case Management. See also Early Intervention Services

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the of Alabama Department of Public Health (ADPH) Service Standards for persons living with HIV, including the following:

1.0 Key Services Components and Activities (include assessment and service plan)	
Standard	**Measure**
1.1) Screening and intake to be completed within 5 days of initial contact with patient.	1.1) Documentation of intake, eligibility screening & needs assessment in patient's record.

1.2) Referral services are not provided as part of Ambulatory/Outpatient Medical Care or Case Management services.	1.2) Documentation of referral services conducted by date of service, type of communication, referral & follow up provided.
1.3) Refer persons who are HIV-positive to medical care within 5 days of intake.	1.3) Documentation with date of persons referred for medical care and/or patient's refusal.
1.4) Determine if referred patients have engaged in medical care within 1 month of referral.	1.4) Documentation of medical visit attendance in patient's record.
1.5) Refer persons who are HIV-positive to appropriate supportive services within 14 days of intake.	1.5) Documentation with date and referral information of persons referred for supportive services and/or patient's refusal.
1.6) Determine if referred patients completed the referral within 1 month of referral.	1.6) Documentation of outcome of referral in patient's record.
1.7) Conduct a reassessment every 90 days to determine additional and/or ongoing needs.	1.7) Documentation of reassessment every 90 days in patient's record.
1.8) Referral for Health Care services According to HRSA National Monitoring Standards develop and implement services to direct clients to needed services. Referral services will: • Direct a client to a service in person or through other types of communication • Possible modes of communication include telephone, phone, email, and/or text messages • Client must specify which mode(s) of communication is acceptable • Staff must maintain client confidentially in all communications • Provide benefits/entitlements counseling and referral	1.8) Documentation of implemented services that directed clients to needed services in patient's record. Documentation of specified mode of communication by client in patient's record.
1.9) **Intake** Staff will conduct an intake within five (5) business days of initial contact with the client to determine eligibility for and need of health care or supportive service referral services.	1.9) Documentation with date of intake, eligibility screening & identification of needs

1.10) Services Benefits Counseling a) Activities should be client-centered facilitating access to and maintenance of health and disability benefits and services. b) It is the primary responsibility of staff to ensure clients are receiving all the benefits/ resources for which they are eligible. c) Staff will educate clients about available benefit programs, assess eligibility, assist with applications, provide advocacy with appeals and denials, assist with re-certifications and provide advocacy in other areas relevant to maintaining benefits/resources d) Staff will explore the following as possible options for clients: • AIDS Drug Assistance Program (ADAP) • Health Insurance Premium Payment • Food stamps • Insurance Continuation (COBRA, OBRA, HIPAA) • Medicaid • Medicare • Pharmaceutical Patient Assistance Programs (PAPS) • Private Insurance • Health Insurance through Affordable Care Act (ACA) • Social Security Programs • Social Security Disability Insurance (SSDI) • Supplemental Security Income (SSI) • Social Security Retirement State Disability Insurance (SDI) • Temporary Aid to Needy Families (TANF) • Unemployment Insurance (UI) • Veteran's Administration Benefits (VA) • Women, Infants and Children (WIC) • Worker's Compensation • Other public/private benefits programs. e) Assist clients who are HIV positive with completion of benefits application as appropriate within fourteen (14) business days of referral intake f) Determine if referred patients completed the application process within 30 business days of referral g) Conduct a follow-up within 30 and 90 days of completed application to determine if additional and/or ongoing needs are present	1.10) Documentation of progress of client enrollment into eligible benefits/resources for which they are eligible for and located in client's file. Documentation of completed follow-up after 90-days to assess if additional needs or benefits are needed and placed in client's record.

1.11) Health Care Services a) Staff will assist clients in accessing available resources for health care entry into and movement through care service systems: • Refer persons who are HIV positive to medical care within five (5) business days of referral intake • Determine if referred patients have engaged in medical care within 30 business days of referral • Refer persons who are HIV positiv to appropriate supportive services within fourteen (14) business days of referral intake b) Determine if referred patients completed the referral within 30 business days of referral	1.11) Documentation of referral made to medical care in client's record.
1.12) **Referral** Staff will follow-up on referrals to determine whether the client accessed medical care and/or other services to ensure that they continue receiving said services and to avoid duplication and to prevent client abuse of the care system.	1.12) Documentation of referral follow-up in client's record.

2.0 Quality Management

National Monitoring Standards: Implement a Clinical Quality Management Program (CQM) to include: a) written QM plan; b) quality expectations for providers and services; c) method to report and track expected outcomes; d) monitoring of provider compliance with HHS treatment guidelines and Part B Program's approved Standards of Care.

Standard	Measure
2.1) Measure and report client health outcomes using referral for Health Care/Supportive Services measures approved by ADPH.	2.1) Performance measurement data on the following indicators: • Percentage of people enrolled in RW Part B-funded Program living with HIV regardless of age and receiving Health Care/Supportive Services, who will have at least one medical visit in each six-month period of the 24-month measurement period with a minimum of 60 days between medical visits (Care marker defined as evidence of a HIV medical care visit date, a CD4 count and test date, a viral load value and test date, and/or an antiretroviral medication prescription and date).

	• Percentage of persons living with HIV and receiving referral for Health Care/Supportive Services, regardless of age, who will have at least two care markers in a 12-month period that are at least 3 months apart (Care marker defined as evidence of a HIV medical care visit date, a CD4 count and test date, a viral load value and test date, and/or an antiretroviral medication prescription and date).

Resources:

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards—Program Part B (April 2013)

HRSA/HAB Ryan White HIV/AIDS Program Services: Clarifications on Ryan White Program Eligibility Determinations and Recertification Requirements Policy Clarification Notice #13-02

Public Health Service Act; Sections 2605(a) (6), 2617 (b) (7) (F), 2664 (f) (1), and 2671 (I).

HRSA/HAB Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice #16-02 (10/22/18)

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. Available at: https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf[ix]

See also Early Intervention Services